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GERIATRIC REHABILITATION:
PERSPECTIVES AND POTENTIALS*

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GERIATRIC rehabilitation deals with the restoration of function and health to the elderly disabled by complications of chronic disease. Disabling episodes become more frequent with advancing years. In our aging society, the number of elderly patients who require physiatric services is fast increasing, and will continue to increase for the next 50 years.¹ This has repercussions on physiatry, medicine, and biomedical research and on the country's economy, politics, and social conscience.

To treat an individual "back to health" when disease has caused permanent damage may seem preposterous to a physician who learned in medical school how to diagnose and "cure" diseases. Disease-oriented knowledge is useful for physicians whose oldest patients are middle aged and who require care for acute diseases or injuries. Most in due time resume their usual healthy lives through their own recuperative powers. Not so the aged

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stroke patient, the amputee, the respiratory cripple, or those with a permanent cognitive impairment, none of whom can return to a premorbid state.

Gerontology has taught us that the elderly respond differently to drugs, are prone to accidents, have reduced sensory input, develop osteoporosis, tend to be socially isolated and mentally depressed, forgetful and, most important, are poorer than the young. All these changes necessitate modification of therapeutic strategies and timing. How then can a permanently disabled individual regain health? What is "health"?

"Health is a complete physical, mental and social well being and not merely the absence of disease or infirmity,"² a definition not applicable to the elderly. In practice, health is "a state in which the individual happens transiently to be perfectly adapted to his environment."³

Many elderly people who live healthy lives have one or more diseases when examined carefully. Conceptually, "health" is opposed to disability and not to disease with which it often co-exists. Health can prevail at different levels of function; a person disabled for strenuous activity may be fit for less stringent demands. After a disabling episode, a person may regain stamina by adapting activities to reduced endurance, strength, or drive. Strength and endurance are assessed by well established psychiatric methods in the ergonomic laboratory, and a precise prescription of tolerable activities is part of psychiatric management.

Clearly, the task of the primary physician who guides his disabled patient in this process of recovery cannot be undertaken on the basis of biomedical knowledge alone, no matter how thoroughly supported by advanced diagnostics. He must have reliable data as to his patient's educational, emotional, and cognitive background, his expectations and anxieties, available environmental resources, and his architectural habitat, all of which are ingredients in the patient's capacity to regain health and that must be assessed in their totality. If cognitive impairment is an important factor, experience is accumulating that this condition is often reversible and is rarely as inexorably progressive as Alzheimer's disease, the widely advertised prevalence of which should be held in abeyance until more reliable data are available.

The methodology for assessing a disabled person's potential restoration of health has been worked out over the past 40 years in departments of psychiatry across the country. Only recently, bits and pieces of similar methodology are being gradually reinvented in departments of internal medicine, psychiatry, and family practice, none of which seem to be aware as they should of psychiatric expertise in geriatric rehabilitation⁴ and of the rich literature of this experience.⁵

THE PHYSIATRIST, THE PRIMARY PHYSICIAN
FOR THE DISABLED GERIATRIC PATIENT

The physiatrist's methods of prevention, diagnosis, and management differ fundamentally from those employed in almost all other medical disciplines.

In primary prevention we try to create a "prosthetic environment": good lighting, less noise, vivid colors, large print signs, push-button telephones, special door knobs, and other environmental adjustments. Secondary prevention protects against deconditioning, pressure sores, contractures, alienation, urinary infections, and other consequences of neglect.

Physiatric diagnosis goes beyond that of existing disease; it includes all data on the patient's potential abilities and environmental resources. These data and the clinical decisions that follow are obtained in the rehabilitation conference, in which all those involved in the patient's treatment participate. Such a task can be carried out only in a multidisciplinary setting; no single person could accomplish it alone. Usually a physiatrist heads this rehabilitation team. Long and short-term goals are formulated and implemented by members of the team, and the results are evaluated at regular intervals.

THE IMPACT OF POLITICS ON GERIATRIC MEDICINE

The scenario in which we are and will be asked to practice our art brings us into the realm of politics and economics. The American health care system has become expensive. We spend more on it than any other nation. The main payers, government and large industrial and business organizations, now that the total yearly outlay for health care has exceeded 400 billion dollars, refuse to pay more.

The Medicare-Medicaid system was designed as an insurance system, leaving cost to the market place. All parties that provided services, hospitals, physicians, other health professionals, and the pharmaceutical industry set their own prices for services or products. Legislators considered such services to be usable goods that lend themselves to the vagaries of the market place. This is a fundamental misconception. Usable goods are valued by demand and supply, and demands depend on the wishes of the consumer. Health care services, however, are furnished because the consumer needs them, and not because he wants them (regrettable exceptions notwithstanding). He may recognize a need, but in our society the kind, extent, and delivery of services (that set their value) are determined by the health professional; the true value rests in the proper choice of services, and the value of identical services may vary considerably for different individuals and different conditions.

If the physician's professional input in setting the value of health services

is basically disregarded, as in the Medicare-Medicaid system, no surrogate system can be found to set a value to clinical judgment based on clinical experience which, in practice, is the most valuable and lofty of all services any patient can hope to receive.

Such a basic omission explains overevaluation of material details of service, where even a surgeon is valued by his technical proficiency and not by his judgment which, in reality, determines his value; or where a physiatrist is valued by the number of tests he can document rather than by the experience that determines his value to the system. It is easy to see how this distortion of our health care system leads to waste and profligacy.

OUR PRESENT HEALTH CARE IS IN FACT A TRIAGE SYSTEM

The Medicare-Medicaid Amendment Acts of 1965 were to provide health care for the aged (Medicare) and the poor (Medicaid). Today it is drifting more and more from its original goal.

It has brought care to millions that previously had been outside any insurance system. It has benefitted those relatively few that required the most modern diagnostic and therapeutic technology to prolong their lives, even if by weeks or months only. It has helped to prolong the lives of thousands who would have died without the blessings of 20th century medicine: a proud achievement indeed! But it has disappointed some 30% of the poor that are still outside any health insurance system, and it has failed a good number of the elderly, particularly those in long-term care for whom no ready solution is in sight.

Human miscalculations are often based on misconceptions. The fee-for-service payment principle that dominated the medical scene prior to the advent of Medicare-Medicaid is now being superseded by a third party pay system. Other nations that have national health plans, including some Canadian provinces that have health insurance plans which in some ways resemble our own,⁶ had to abandon the fee-for-service principle which weakened the physician-patient relationship which we had believed in for years. In spite of this development, their health care system, which includes their whole population and provides for long-term care, has not proved as expensive as ours.

Another misconception inherent in the Medicare-Medicaid act was the assumption that all modern medical care belongs in hospitals or nursing homes. Postwar building of hospitals and nursing homes⁵ had set the stage for this illusion. Today we understand that the place of the hospital in the spectrum of nationally available health services is at the top when it deals with life-

threatening emergencies in intensive care units. The position of the nursing home care was practically nil in spite of rhetoric to the contrary. Medically ill. Any system that ignores the value of the many intermediate services to the system, and which gives little credence to the monetary (and psychological) advantages of the patient's community as home for the vast majority of disabled or diseased elderly individuals will prove wasteful.

Medicare had no provision for community care, except for 3% of its budget for skilled nursing care, and Medicaid devoted only 1% of its budget to community programs. Thus, government aid for any but hospital or nursing home care was practically nil, in spite of rhetoric to the contrary. Medicare allots 70% of its huge budget to only 8.8% of its subscribers,⁸ for the organ transplants, dialyses, microsurgical procedures, cataract implants, and other expensive services. Thus, 30% of its funds go to 91% of its subscribers. Obviously, this "triage" system begs for national debate on health priorities and fairness in health care fund distribution. Such a discussion ought to be sponsored by Congress, with input from unbiased medical experience. Presently, out-of-pocket costs are growing for the elderly who can hardly afford it.

By the beginning of the 1980s the astronomic rise in cost of health care became an immediate threat to the survival of the system. The natural increase in health care costs, however, was inherent in the system from growth of the population, rising prices of hospitals, and the continued open utilization of novel technology⁹ as the population aged and as malpractice insurance costs played an additional part. All levels of government, industrial and private corporations, labor unions, and the general public, all of whom shared in the burden of costs, became gravely concerned. To halt or to reverse this natural rise of cost without compromising quality of care could be achieved in only two ways: regulation or innovation, meaning attempting new methods of cheaper health care or new forms of financing.

Some limited control had been built into the system: expended funds had to be accounted for, first to the utilization review committees, then through the professional standard review organizations, both of which functioned just about adequately. But a heavy-handed bureaucracy which devoured needed funds and regurgitated them into paperwork proved an ogre. Some 70% of the time and energy of highly trained and motivated professionals often went into redundant and wasted paperwork. The elderly in need of care were victims, their funds wasted in paper documentation.

The governmental squeeze of the 1980s has been the DRG system, the only purpose of which was to save money. Quality of care could rightly have

been expected to suffer. Ironically, the opposite might have occurred on both counts. We have had the DRGs in New Jersey for almost five years, and the final account seems to show that it costs more, but it has made home care more accessible to chronically disabled aged people who previously had a good chance to land in a nursing home to live in misery and die within two years.

Catastrophic health insurance has long been overdue. Now, finally, we have a Secretary of Health, Otis Bowen, M.D., who understands the overwhelming need for such insurance, and who is the first politician to meet the problem head on by proposing some modification of the Medicare-Medicaid act, although within the constraints and political biases of the present administration.

In a climate of unrelenting shrinking of governmental funds for sick or disabled people and the obvious need to promote home care, such programs today are initiated in many parts of the country, supported by private funds. They counter, in a modest way, the unfair distribution of health care funds.

Social changes favorable for community care are emerging. HMOs use fewer hospital days for their members;¹⁰ three- and four-generation families in large cities may be becoming more cohesive;¹¹ young family members intend to take over more responsibilities for their family elders;¹² single elderly people often tend to share homes;¹³ and home care receives stimulation from many sources,¹⁴ from government, hospitals, religious groups, private corporations, private groups, industry . . . from all corners of the country. Still, there is little or no interest in home care among the medical profession, a neglect hard to understand and a great opportunity missed, particularly for the primary physicians of the disabled elderly, physiatrists. They are committed to continuity of care for the disabled elderly, from the acute episode in the hospital to restoration and maintenance of health in the community.

Modest provision for home care was included into the Medicare-Medicaid acts, and since 1971 the Medicare contribution has grown by a yearly 20% to one billion dollars in 1981, with similar increases for Medicaid. Home care total outlay in 1982 was two billion dollars and is believed to have doubled in 1985.¹⁴

But now, with the DRGs we see patients at home who have real medical problems. Parenteral nutrition, intravenous (even central) lines, all sorts of antibiotics, chemotherapy, narcotics, renal dialysis, and even cardiac pressor agents¹⁴ can be given at home. Ventilation techniques can be administered, rehabilitation therapies can be given, and those who need more aggressive

therapy after premature DRG discharge from the hospital can be served at home. Medical supervision is prudent for these services.

Prior to the event of Medicare-Medicaid, many elderly disabled or cognitively impaired aged people had difficulties in being accepted back into their families, usually for one or more of four reasons: behavioral aberrations, complete dependence in activity of daily living, incontinence, and total inability to move about, in or out of wheelchair.

Home care services are sponsored by a large number of agencies and groups, for profit or not-for-profit, religious groups, hospitals, by private entrepreneurs. All must be licensed by the state, but only 25% are certified and can be paid by Medicare or Medicaid. The range of services offered is large and uneven. The physician signs his name to approve treatment planned by others whom he may not know for patients with acute or chronic problems he may not know. It seems timely for physicians to get more involved in the increasingly sophisticated home care services. Koren rightly points out¹⁴ that the medical profession must get involved in home care on a policymaking level. Home care is spreading and soon will be "regulated" by government and bureaucracy. Her idea, to link the medical school to the system by assigning faculty members to individual home care services, seems most appropriate since it would facilitate the teaching of home care in the medical curriculum of the future. Home visits by physicians will again be popular.

Even though we physiatrists are not working under DRG rules, we feel their impact every day. Hospital patients who develop medical complications are turned over to their primary physician and are readmitted when acute episodes are under control. The rigmarole of frequent discharge-readmission sequences are costly and cumbersome, and the patient often leaves the hospital in worse condition than when he came in. If a premorbid level of function is not reached, the physiatrist may become the primary physician, overseeing his patient's restoration to and maintenance of health.

We physiatrists have to renew our commitment to continuity of health care for aged disabled patients from hospital to final restoration and maintenance of health in their community. This is our future, our opportunity, especially for the younger physiatrists in our midst who are well trained and committed to our health-oriented approach. We must not throw our opportunity away, it will not last much longer!

CONCLUSION

Geriatric rehabilitation is concerned with the restoration of health to dis-

abled geriatric patients; today, it is the domain of physiatrists. In contrast, other medical specialities deal with acutely diseased or injured patients. If such patients happen to be old, gerontology has taught us to adapt our diagnostic and therapeutic options to the evolutionary changes in senescent humans. Many acutely diseased or injured elderly will return to their usual lives in due time.

The patient who emerges from an illness with a handicap, impairment, or disability, however, cannot return to a premorbid state. His restoration to health starts with accepting a permanent deficit and proceeds with adjusting activities to lower levels of physical, mental, or emotional demands, a difficult process that requires support and guidance.

Physiatry has developed multidisciplinary methods unknown to "disease-oriented" medicine by applying preventive measures, by assessing and canvassing the patient's physical, psychological, and social resources, and by helping to rearrange the patient's environment so that some function and worthwhile level of health can be restored in a usual environment.

In the present national climate, the care of the disabled elderly has become an obstacle course for "consumer" and "provider" alike. Medicare and Medicaid were originally conceived as health insurance for the aged (Medicare) and the poor (Medicaid), but left the actual cost to the market place which caused the system to grow wasteful and inherently expensive. Yet, this insurance system has brought millions into the health care system and has saved lives by exposing them to the blessings of modern medicine. But 30% of the poor are still outside the system and long-term care is not provided, while per capita costs continue to rise.

The vast but not unlimited funds available for health care are presently predominantly spent for hospital-based, costly, hi-tech diagnostic and therapeutic procedures. Thus, only 30% of the Medicare budget is left to serve the needs of more than 90% of their subscribers.

Only a national debate initiated by Congress could establish whether the time is ripe for a fairer distribution of health care funds. In the meantime, an auspicious expansion of community care, including home care services, is in full swing. It was initiated and is in large part financed by private funds, but the medical profession is not as yet adequately engaged in its development.

The physiatrist in particular who is concerned with the elderly disabled must more actively participate in the movement of health care back to the community; it will be part of his essential role in geriatric rehabilitation.

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